Psychological Aspects of Pain in Patients with Terminal Cancer

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• **The dying patient reacts emotionally to the problems encountered in the terminal period according to his established pattern of response to stress. The nature of this pattern will play a part in his experience of pain. Some of the types of reaction include the bizarre misinterpretation of bodily sensation of the psychotic, the development of conversion symptoms, the increase in pain through muscle tension in the anxious but overcontrolled person, and the stoical acceptance by guilt-ridden patients.**

Physicians are sometimes reluctant to devote full attention to the care of the terminally ill for a number of reasons, including the attitude that "curing" is the only worthwhile activity of a doctor of medicine.

Observers have found that the physician's attention to the day to day anxieties of the patient in a terminal stage may contribute substantially to his comfort.

THE OLD RIGID division of pain into organic pain and functional pain is falling away. In its place we have what Sasz[8] has called the two components of pain. One is the medical portion which involves the physical disturbance in an organ of the body and the transmission of an impulse to the central nervous system saying that something is wrong. The other component is the communicative aspect of the pain and has to do with the cry for help to another person.

This second component may then have complex elaborations depending upon the personality and past history of the person involved. And the medical component, of course, will have many variations depending on the stage and type of disease involved. The important point to emphasize is that both components will always be present simultaneously in varying combinations.

Few psychiatrists or psychologists have studied the dying patient but those who have report that there is no revolutionary change in the patient's characteristic pattern of behavior at the threat of death. However, what is seen is an intensification of the person's usual methods of dealing with stress. In other words, if it has been a man's lifelong pattern to regress, feel helpless, be childishly demanding in the face of stress, then this will be his pattern in the terminal situation too. If he has always dealt with threats by a denial and a stoicism, then this will tend to be his pattern still. It is this observation which justifies our applying certain conclusions about psychogenic pain in other situations to the terminal cancer patient.

I would like to cite some examples of the ways in which psychologic and emotional factors shape the expression of pain in general, then apply these models to the specific situation in the cancer patient in the terminal state, ending with some remarks about treatment.

A schizophrenic patient whose perception of the outside world is so disturbed that he believes that people are plotting against him when such is not the case may also have so distorted an impression of his inner world—his body—that his descriptions of what he may call pain are quite bizarre and puzzling. He may speak of his organs rotting or of his stomach being dead.

Such a patient experiences and expresses consciously what the rest of us may feel unconsciously. For instance, the image of cancer as a living thing which eats one from the inside is universal. Indeed the word cancer means crab. One may say that this is in fact what cancer is, but there is quite a difference between the vivid image of a live animal actually biting and consuming our bodies and the medical picture of disordered cell growth. It is just such unconscious psychological images which may contribute to the psychologic component of pain in the patient with terminal cancer.

An example of the way psychological image can grossly affect the expression of pain is given by Kolb.[7] He described a 14-year-old boy who had his right leg amputated. Immediately following the amputation he complained bitterly of a burning pain and writhed constantly in bed, crying out for help. No drug treatment could relieve this pain. When the psychiatrist came to see him he asked the boy about the existence of phantom limb sensation. The boy replied that he had such a feeling and then told a story which he recalled hearing at school. The story related that a man who had an amputation continued to have pain afterward. When nothing could be found to relieve him, the man's amputated ex-

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tremity was disinterred—so the story went—and it was discovered that ants were eating the limb. When the boy was asked what he thought was being done with his own limb, he replied that he thought it was probably being burned. After he was told that his leg was not being burned the severe pain subsided to a large extent. The conclusion may be drawn that this boy's unrealistic fantasy played some role in the cause of his pain.

This psychological mechanism is called conversion because a symbolic idea (in this case the limb being burned) is converted into a bodily sensation. The phenomenon of conversion may well take place also in the patient with terminal cancer and be stimulated both by the presence of a diseased organ and by fear of death. It is easy to see, for instance, how this image of a part of the body burning could represent for the dying patient his fears of eternal punishment after death.

Another mechanism which is often involved in pain is the pain from muscle tension. It is obvious that a patient with terminal cancer may be particularly liable to such pain when he braces himself for the pain he experiences, when he braces himself for visits by relatives with whom there may be conflicting feelings or when he struggles with his feelings about approaching death.

As mentioned at the beginning, there is an element in pain which has to do with communication with other people. Thus the conversion symptom of pain not only serves a purpose within the psyche of the patient but it also serves a purpose in his relationship with others. For instance, a conversion symptom of pain may not only express the idea of self-punishment for a sense of unconscious guilt but it may also express the idea to a loved one, "See how much I'm suffering!" Such pain may also express the idea, "Help me," and may simply be a call for some attention which the patient needs greatly but cannot ask for in any other way.

With these general considerations in mind, let us look at the specific problems of the patient with terminal cancer. For our purposes we will define terminal as the final stage at which nursing care is necessary. Such a patient is confronted with at least three kinds of stress—an increasing degree of helplessness, pain and, in one degree or another, a knowledge of approaching death. The individual patient's reaction to these stresses then will be ac-according to his established pattern.

In our society the virtues of self-reliance and independence are so highly valued that many people feel a great deal of shame and humiliation at the idea of having to be taken care of. This may lead to such tension that pain may be intensified by the consequent increased muscle tension. It is also possible that conflict over this dependency may lead to a demand that the physician get him well. This demand may be expressed through an increase in the intensity of the pain as a way of saying, "Do something to get me well." It is also possible that a patient feels such a sense of guilt about the need to depend on others that his pain becomes a method of self-punishment and also a way of saying to himself, "Look—I'm justified in having to depend on others because I'm suffering so much."

At the other extreme some patients may have developed the kind of personality which accepts and embraces a sense of helplessness at any stressful situations they meet. Such people as this may be very passive in their attitudes, seldom complaining aggressively of pain, but always stating in response to questioning that they are having pain, although showing no facial or other expression to indicate that this is the case.

Physicians and nurses who themselves are children of our culture, tend to like the stoical patient because he makes fewer open demands upon them. However, I think one must take a second look at the uncomplaining patient who insists on doing all he can for himself. I think that in so doing we may find that his emotional needs may be finding some other expression which may require our attention.

With regard to the stress of experiencing physical pain, the pattern of reaction may be one in which the pain is quietly accepted as his due punishment by a guilt-ridden patient who has felt all his life an unconscious need to atone for imagined crimes. Or it may be a realistic, forceful expression of discomfort by a relatively well integrated person. Or it may be a whining, tearful, dramatic plea from a person whose personality pattern has remained at a childhood level.

The physical pain may also become a part of a neurotic conflict. For example, a study by Finesinger and Abrams[1] (to be discussed later) describes patients with cancer who had the idea that their malignant lesions were in some way the result of venereal disease. This expresses a continuing sense of guilt about venereal disease and continuing neurotic conflict about past sexual activities. If such patients also have pain from cancer involving the reproductive system, the pain may then be intensified by its involvement in this conflict.

The stress involved in the knowledge or the half-knowledge or the suspicion that death is near is difficult to study and evaluate. Feiffel,[5,6] a psychologist who made research studies involving the interviewing of patients in a terminal state, reported that he had great difficulty in getting the cooperation of hospitals and physicians, and he attributed their resistance to the general abhorrence of the subject of death in our culture. Many observers have commented on the American supreme effort to deny the

reality of death. The use of euphemisms such as "passed away" and "departed," the expectation that bereaved persons will keep their grief to themselves, and the use of such a word as "foreverness" all indicate the abhorrence we feel for this inevitable reality of life. Since it seems to all of us so natural to dread and hate death, it is difficult for us to examine the factors that go into what we accept as the "natural" fear of death. For some it may mean the horror of eternal, painful punishment. I do not mean just those people whose conscious adult religious belief is in a literal hell. The same notion may be present unconsciously in someone who consciously would express profound skepticism about such a belief. This unconscious concept may be the result of long and deeply repressed ideas from childhood.

For others, death may mean a horror of the unknown, and some may fear that the process of dying in itself will be an agony. The idea of loss of one's self motivation may be dreadful to some persons, while for others the leaving of loved ones is paramount. Still others may look upon death as an enticing dream of eternal peace in which one may be reunited with persons he loved who died. And death may mean all these things and others to one and the same person.

Granted that these and many other fears may be involved when a patient reaches a terminal stage of illness, what bearing may this have on his pain? The commonest form that the attempt to deal with all these fears takes is denial. That is, the mind simply says, "It isn't so that I'm going to die." This phenomenon is the same that takes place in combat when the infantryman says to himself, "It won't be I who gets hit." And it is the same as that which occurs when one has lost a loved one and at first feels no sense of loss. There are degrees of denial. That is, some patients may simply never admit that they are going to die, while others may at one time seem to understand perfectly well what is happening and make plans accordingly, and then, a short time later, behave as if they were planning to live on. It is as if the mind were able to tolerate only for short periods this idea of death. Most investigators who have written about psychological aspects of dying—Eissler[3] for example—feel that for most patients some degree of denial is desirable and should be encouraged by the physician.

Some authors feel that there is an optimum balance between denial and acceptance of the approaching death. One can certainly see that if the denial were too strong it might have a reflection in the patient's experience of pain. At least this is true if it is valid to apply a principle from work with phantom limb pain in amputees. In this group it appears that the persistence of severe phantom limb pain may be associated with a need to deny the loss of the limb. In such a case the pain is a kind of insistent message saying to the patient, "My limb isn't really gone; how can it be, when it hurts so much?" If we apply this idea to patients with terminal cancer, then we might suspect that too forceful a denial could result in increased pain which is saying, "Look—I'm still alive." In this connection, it is of interest to note that some observers, particularly social workers who have worked with the families of patients who have terminal cancer, have found that the families (and sometimes the hospital staff) may treat the patient as if he were already dead as soon as they find that he is, indeed, in the terminal stage. These observers feel that the communication of this feeling by facial expression, manner and voice may be very deleterious to the morale of the patient. It is understandable that such a situation might set off an episode of increased pain as a way of forcefully letting everyone know that he, the patient, is still around.

Thus, fear, apprehension and despair in the patient and his family may show itself in an increase in the severity of the patient's pain. We should begin our consideration of treatment, then, with the question of what the physician can do to minimize such emotional complications. Immediately we have to look at the attitude of the physician, for it is necessary that he believe that this function in the care of patients with terminal cancer is legitimate, worthwhile and important. Sonkin,[9] in describing the experience at New York Hospital with a home care program, reported that there was wide variation in the approach of physicians to the care of patients in the terminal stages of disease. The idea was openly expressed by one physician that it was a waste of time for a physician to attend a patient "for whom nothing more can be done medically." Such an attitude, although perhaps seldom openly expressed, is, I think, not unusual. It is undoubtedly related to the attitudes which were mentioned by Feiffel[6] when he found so much opposition to working with such patients. The notion that it is the physician's role to cure and that anything less than this just does not count is certainly common.

Many, perhaps most, physicians have been in part motivated in their choice of medicine by an unconscious "rescue fantasy." The famous psychiatrist, Alfred Adler, told in his autobiography of an experience in his early childhood in which he had a serious illness, was near death, and was saved by medical intervention. This experience set his ambition to become a physician and do the same. Such a drive is, of course, constructive and useful to a degree. However, its usefulness is gone when we let it become so rigid that any experience which does not fit into the form of a rescue operation becomes unacceptable. If the physician feels that the inevi-

table fact that the patient will die is a threat to his notion of himself as savior, then he will turn away from these patients in terminal stages and lose an opportunity to be useful.

Assuming that the physician can overcome some of this reluctance to work with such patients, how can he be helpful? First, one can help by a willingness to listen to what the patient or his family may be needing at any given moment. Feiffel[5,6] found that, although the medical staff at first objected to permitting interview of patients in terminal stages, once interview was allowed, many of the patients expressed their gratitude for the opportunity to talk about their feelings about death and their current state. Many reported later that they felt relieved and calmer after talking even though the interviewers had seen the patients principally for research purposes and had no therapeutic objectives in mind. The first point, then, is to ask oneself: "Am I hurrying out this patient's room because he is in the terminal state or am I giving full attention to what may be done for him at this point?" Perhaps one hurries out because he does not know how to answer the patient's questions. Of course, what one tells a patient about his illness has to be decided case by case, taking into account the personality of the patient, the realistic needs of his job and family and such factors. However, there are certain general principles which apply to every case. One is that the physician should attempt not to communicate fear, disgust, horror or hopelessness in his manner and attitude. On the other hand he should not assume what is often a transparently false cheerfulness in the face of a grave situation. He should not treat his patient as if he were already dead. He should remember that he does not really know the prognosis for certain.

Everson[4] studied reports of 1,000 cases of spontaneous regression of cancer collected from the world's literature. To date he has irrefutable proof of remission in only 90 cases, but this is enough to validate the essential point that in no case do we *know* the prognosis. I recently had experience with a case in which an x-ray film of the chest one year after a radical operation for cancer was read, first by a radiologist and then by a group of physicians at a staff conference, as showing multiple metastasis. Now, three years later, the thoracic lesions have grown smaller without treatment and are considered to have been some other process. At the time the x-ray film was taken, the decision was made after discussion with the family to tell the patient that there was something in his chest but we did not know what it was. He did not press the point but probably made his own assumption that it was not cancer. We felt we were not telling him the whole truth when we said we did not know what it was; the fact was, we *were* telling him the truth.

One study of Finesinger and Abrams[1] showed that in a group of cancer patients, including ten who were in a terminal stage, all showed some feelings of guilt about the disease. These feelings came out usually in the patient's attributing the cancer to some past misdeed or failure on his part. This sense of guilt may certainly contribute to the degree of pain since, as we have mentioned, the need for punishment to satisfy unconscious guilt is a common mechanism in psychogenic pain. The physician ought to be alert to indications of this attitude so that he can try to relieve some of the guilt.

Another important way that a physician may contribute to the ease of the patient in a terminal state is in dealing with the fears of the family so that the patient will not be unduly burdened by their emotional reactions. In this task as well as with many practical problems he may call upon the skilled social worker for help.

In connection with the family I would like to conclude with a quotation from a recent article by Ayd[2] on "The Hopeless Patient":

"Doctors are not the only critics of our ministrations to the dying. Lay people who have witnessed an expiring loved one's ordeal prolonged by oxygen, stimulants and tubes inserted into natural and surgically created bodily orifices also are our censors. They resent being deprived of the opportunity to share the waning moments of life with the one they love. For years they have shared joys and heartaches. Why, when they could face the greatest of all crises together must they be shoved out of the room, displaced by gadgets and personnel striving to delay the inevitable?"

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